Reimbursement Information for Contrast Enhanced Spectral Mammography (CESM) Services

April, 2016

gehealthcare.com/reimbursement
This advisory addresses Medicare coding, coverage and payment for mammography Contrast Enhanced Spectral Mammography (CESM) procedures performed in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings. While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

For purposes of this advisory, diagnostic mammography refers to a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer or a personal history of biopsy-proven benign breast disease. Screening mammography refers to a radiologic procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. CESM is an extension of the existing indication for diagnostic mammography, and can be used as an adjunct following mammography and ultrasound exams to localize a known or suspected lesion.


The following provides 2016 national Medicare Physician Fee Schedule (MPFS) and facility payment rates for CPT codes that may be used to report CESM procedures. Payers or their local branches may have specific coding and reimbursement requirements and policies. Before filing any claims, it is recommended that providers verify current requirements and policies with their local payer. Payment will vary by geographic regions.

Table 1: 2016 Medicare Reimbursement for Contrast Enhanced Spectral Mammography Procedures (Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>Technology</th>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>APC</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital</td>
<td>HCPCS G0204</td>
<td>Professional (-26)*</td>
<td>$44.40</td>
<td>N/A</td>
<td>$120.66</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)**</td>
<td>$120.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$165.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital</td>
<td>HCPCS G0206</td>
<td>Professional (-26)</td>
<td>$35.45</td>
<td>N/A</td>
<td>$94.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)</td>
<td>$94.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$129.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td>CPT 96374*****</td>
<td>Facility**</td>
<td>N/A</td>
<td>APC 05693</td>
<td>$92.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Facility***</td>
<td>$57.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Professional – is the physician payment.
** Technical – is the facility payment.
*** Facility – is the payment made to the physician when the procedure is performed in a hospital or ASC.
**** Non-Facility – is the payment to the physician when the procedure is performed in the physician’s office.
***** Requires direct physician supervision – physician must be immediately available in office.
2016 Medicare Reimbursement for Contrast Materials

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Dosage</th>
<th>Payment Limit¹⁰</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Q9951</td>
<td>Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml</td>
<td>Not Available</td>
</tr>
<tr>
<td>CPT Q9965</td>
<td>Low osmolar contrast material, 100 – 199 mg/ml iodine concentration, per ml</td>
<td>1 ML</td>
</tr>
<tr>
<td>CPT Q9966</td>
<td>Low osmolar contrast material, 200 – 299 mg/ml iodine concentration, per ml</td>
<td>1 ML</td>
</tr>
<tr>
<td>CPT Q9967</td>
<td>Low osmolar contrast material, 300 – 399 mg/ml iodine concentration, per ml</td>
<td>1 ML</td>
</tr>
</tbody>
</table>

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of radiologic procedures for CESM services.

26 – Professional Component

A physician who performs the interpretation of a mammography exam in the hospital outpatient setting may submit a charge for the professional component of the mammography service using a modifier -26 appended to the appropriate radiology code.

GG - Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

When a screening mammogram and a diagnostic mammogram are performed on the same patient on the same day, modifier –GG would be appended to the appropriate procedure code. The screening mammogram is reported and the diagnostic mammogram is reported (different encounters on the same day).

GH – Diagnostic mammogram converted from screening mammogram on same day

When a diagnostic mammogram is converted from a screening mammogram on the same day, modifier -GH would be appended to the appropriate procedure code. A potential problem was detected by the interpreting radiologist and, therefore, the radiologist will also perform a diagnostic mammogram at the same visit.

TC – Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

Hospital Inpatient – ICD-10-PCS Procedure Coding

ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting. The following are ICD-10-PCS procedure codes that are typically used to report radiological procedures for mammography services.

- BH00ZZZ Plain radiography of right breast
- BH01ZZZ Plain radiography of left breast
- BH02ZZZ Plain radiography of bilateral breasts

ICD-10-CM Diagnosis Coding

It is the physician’s ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the mammography.

Documentation Requirements

As with any procedure performed, Medicare requires documentation to support that the procedures performed are medically necessary. Medical necessity, as determined by the payer, should be thoroughly documented in the patient’s medical record. Medicare will reimburse providers for medically necessary screening and diagnostic mammography procedures that are performed on the same patient on the same day. The modifier –GG “Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day,” must be attached to the appropriate diagnostic mammography procedure code. In a scenario where a patient has a screening mammogram performed on one day and returns on another day for the additional diagnostic mammogram, both the screening mammogram and diagnostic mammogram services should be coded separately without the use of modifier –GG. This policy applies to both film and digital mammography procedures. (Refer to the Medicare Claims Processing Manual at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf [scroll to section 20.2]).

Payment Methodologies for Mammography Services

Medicare reimburses for mammography services when the services are within the scope of the provider’s license and are deemed medically necessary. The following describes the various payment methods by site of service.

Medicare reimbursement for mammography services is comprised of a professional component (PC), which is the amount paid for the physician’s interpretation and report, plus a technical component (TC), which the amount paid for performing the service (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the total or global reimbursement. Regardless of the site of service, diagnostic and screening mammography services are paid under the Medicare physician fee schedule.
Payment Methodologies for Mammography Services (continued)

Table 1 provides information concerning Medicare national payment amounts for both screening and diagnostic mammography services performed in the hospital outpatient department, IDTF and physician office sites of care. Note that Medicare payment amounts and coverage policies for specific procedures will vary by geographic location. For more information about reimbursement rates in your area, consult your local Medicare contractor.

**Site of Service**

**Physician Office Setting**
In the office setting, a physician who owns the radiology equipment and performs the service may report the global code without a ~26 modifier.

**Hospital Outpatient Setting**
When the mammography service is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service.

If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the mammography service as an outpatient service.

**Hospital Inpatient Setting**
Charges for the mammography services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless. Note: Medicare reimburses for services when the services are within the scope of the provider’s license and are deemed medically necessary.

**Coverage**
As established in legislation, Medicare provides conditions of coverage for both screening and diagnostic mammography services. Coverage guidelines address the types of services covered; requirements for providers of service; patient’s eligibility; and frequency limitations. To review information on Medicare’s coverage conditions for mammography services, refer to Medicare’s National Coverage Determination, Mammograms, in the Internet Manual for Medicare National Coverage Determinations at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part4.pdf (scroll to section 220.4), as well as information located in the Internet Manual for Medicare Benefit Policy at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf (scroll to section 280.3). However, Medicare may consider CESM to be a new breast imaging modality. Therefore, it is best to check with your Medicare Contractor regarding the coverage of CESM.
Disclaimer

THE INFORMATION PROVIDED WITH THIS NOTICE IS GENERAL REIMBURSEMENT INFORMATION ONLY; IT IS NOT LEGAL ADVICE, NOR IS IT ADVICE ABOUT HOW TO CODE, COMPLETE OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER’S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS AND BILLS FOR THE SERVICES THAT WERE RENDERED. THIS INFORMATION IS PROVIDED AS OF APRIL 2016, AND ALL CODING AND REIMBURSEMENT INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE. PROVIDERS OR THEIR LOCAL BRANCHES MAY HAVE DISTINCT CODING AND REIMBURSEMENT REQUIREMENTS AND POLICIES. BEFORE FILING ANY CLAIMS, PROVIDERS SHOULD VERIFY CURRENT REQUIREMENTS AND POLICIES WITH THE LOCAL PAYER.

THIRD PARTY REIMBURSEMENT AMOUNTS AND COVERAGE POLICIES FOR SPECIFIC PROCEDURES WILL VARY INCLUDING BY PAYER, TIME PERIOD AND LOCALITY, AS WELL AS BY TYPE OF PROVIDER ENTITY. THIS DOCUMENT IS NOT INTENDED TO INTERFERE WITH A HEALTH CARE PROFESSIONAL’S INDEPENDENT CLINICAL DECISION MAKING. OTHER IMPORTANT CONSIDERATIONS SHOULD BE TAKEN INTO ACCOUNT WHEN MAKING DECISIONS, INCLUDING CLINICAL VALUE. THE HEALTH CARE PROVIDER HAS THE RESPONSIBILITY, WHEN BILLING TO GOVERNMENT AND OTHER PAYERS (INCLUDING PATIENTS), TO SUBMIT CLAIMS OR INVOICES FOR PAYMENT ONLY FOR PROCEDURES WHICH ARE APPROPRIATE AND MEDICALLY NECESSARY. YOU SHOULD CONSULT WITH YOUR REIMBURSEMENT MANAGER OR HEALTHCARE CONSULTANT, AS WELL AS EXPERIENCED LEGAL COUNSEL.

1 Information presented in this document is current as of April 1, 2016. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2 The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment’s FDA-approved labeling as a non-covered service.

3 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

4 Title 42- Public Health. CFR §410.34(a).

5 The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. Actual Medicare payment rates may vary based on any deductibles, copayments and sequestration rules that apply.

6 Current Procedural Terminology (CPT) is copyright 2015 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

7 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in the Federal Register (Vol. 80, No. 220 / November 16, 2015) and subsequent updates based upon legislation enacted by CMS. These changes are effective for services provided from 1/1/16 through 12/31/16. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

8 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system. The payment amounts indicated are based upon data elements published in the Federal Register Vol. 80, No. 219 published on November 13, 2015. These changes are effective for services provided from 1/1/16 through 12/31/16. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

9 PMIC Digital Book Series HCPCS 2015. Copyright 2014 by Practice Management Information Corporation, Los Angeles, CA 90010. All rights reserved.

10 Payment allowance limits subject to the ASP methodology are based on 3Q15 ASP data. The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim. Effective January 1, 2016 – March 31, 2016. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html.

11 Title 42- Public Health. CFR §410.34.

www.gehealthcare.com/Reimbursement. Product may not be available in all countries and regions. Contact a GE Healthcare Representative for more information. Data subject to change.

© 2016 General Electric Company.

GE, GE monogram and SenoClaire are trademarks of General Electric Company.

GE Medical Systems Ultrasound & Primary Care Diagnostics, LLC, a General Electric company, doing business as GE Healthcare.

Reproduction in any form is forbidden without prior written permission from GE. Nothing in this material should be used to diagnose or treat any disease or condition. Readers must consult a healthcare professional.